DIAA COVID-19 ATHLETE/COACH SCREENING FORM

School:		Date:									
Screener:								Qualified Healthcare Professional:			
Name Print	Time	Fever>100.4		Cough		Sore Thro		Shortnes Breath	s of	Close Contact or Care wit One with Covid-19	
		yes	no	yes	no	yes	no	yes	no	yes	no
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